BPHC Cooperative Agreement Quarterly Call

Moderator: Stephanie Crist
May 16, 2013
1:00 pm CT

Coordinator: Welcome and thank you for standing by. I would like to let you know that all your lines will be on a listen-only mode until we go to the question answer session of today's call.

If you do have a question you can press star 1 on your touch-tone phone. Today's call is being recorded. If you have any objections you may disconnect at this time.

And now I'll turn the call over to Ms. Tracey Orloff. Ma'am may begin.

Tracey Orloff: Thank you very much. Good morning good afternoon to everybody on the call. We're really glad to be here talking with you today.

I'm going to get the calls started and we're going to have move around our agenda a little bit. Jim Macrae and Tanya Bowers will be joining us in a few more minutes but we thought we'd get going.

And so we have Colleen Meiman here from our Office of Policy...

Woman: Analysis.

Tracey Orloff: ...Analysis and Evaluation.

And she's going to give us an update I was going on with CMS and the Qualified Health Plans. We know that's been a concern to a lot of you. And so we thought it would be better to give you some up to the date information so with that Colleen?

Colleen Meiman: Great. Thank you everybody. Just before I launch specifically into the essentially the Qualified Health Plan information I wanted to make sure that you were all aware of a couple of resources that are out there in the ACA generally.

First of all if you go to the HRSA Webpage hrsa.gov and hit\affordable care act -- you have to actually spell it out -- you will find a lot of information about the ACA that is specific to HRSA programs and providers.

So if you're looking for information that's a good place to start for information for the level of work that we do the people on this call.

Another place that hopefully you are all well familiar with by now is healthcare.gov. This is the official consumer, i.e., and/or public facing Web site that is run by CMS.

But if you were looking for basic information to share with members with patients about what's going on with the ACA that is a very good first place to send people.

It's also good to put it in your favorites marked listing anyway because that is where the access point to the state marketplaces is going to be housed for most states or perhaps all states this fall.

So please make sure you have both of those. You take a look at both of those hrsa.gov/affordable care act and healthcare.gov.

And so as I'm sure you all know we are only about seven months away from the implementation of the largest parts of the Affordable Care Act the two coverage expansions the first one being the Medicaid expansion this optional across states and the second one being the establishment of health insurance marketplaces in all states.

In terms of Medicaid about half about 20 states have come on board so far saying that they are going to expand Medicaid.

There are a few others have said not. There are many others that are still on the fence. And - a useful piece of information to know about the Medicaid expansion is that there is no hard and fast deadline for states to determine if they are going to expand Medicaid.

In theory a state could decide to expand Medicaid effective January 1, 2014 - they can make that decision and submit the appropriate paperwork to CMS as late as March 31, 2014. They can do it 90 days retroactive as long as it's done by the end of a quarter.

So if your state has not yet decided whether or not it's going to expand just be aware that that is there's not a deadline that they've missed it's

something that can be done at any time even up to three months retroactively.

Okay in terms of the marketplaces and as you're probably aware marketplace is now the preferred term for what we used to refer to as exchanges but they are the same thing so don't get confused but don't think you're missing something if you're confused between the two terms.

The marketplaces are the sites Web sites for lack of a better thing to point to where individuals will be able to go and apply for coverage.

And if they meet certain income and other requirements for private insurance they will be eligible to get subsidies for - towards their premiums and also reductions in their cost sharing.

Also the marketplaces will be a place where people can go to determine - they can go through the same portal where you sign up for private insurance and use that portal to determine whether or not they are eligible for Medicaid.

So anyways we'll be taking a great lengths later in this call about the issues around helping people access and get through that portal to determine their eligibility for Medicaid or for subsidized or non-subsidized coverage through the marketplace.

But one piece I want to address right up front is the participation of health centers and other types of safety net providers in the plans that were going to be offered through the marketplaces.

And the term the official term or acronym for these plans is Qualified Health Plans or QHP. That means the plans that are being offered through the marketplaces.

As you may be aware there are requirements in the law and in the regs about QHP's needing to contract with a subset of essential community providers.

And by Essential Community Providers or ECP's mean roughly safety net providers and FQHCs are considered an ECP.

There are guidelines that have been established in the states that are running their own marketplaces they have their own guidelines.

For the majority of states that have federally managed - marketplaces or as partnership marketplaces the feds put out those guidelines.

They were perhaps not as stringent as some people might have expected going into them but the important thing to know is that at least in federally facilitative marketplaces QHP's had to submit their applications by May 2 telling about everything they're planning - all the details around their plans and including the names of the potential community providers with whom they are planning to contract for 2014.

So these plans are - these applications are now being reviewed by the marketplace staff. But please be aware that if you have an FQHC who is interested in contracting with a Qualified Health Plan and has not done so far know that they dead - the May 2 deadline was for the QHP's to submit their information to the marketplace.

It does not mean that they cannot add additional providers to their network after that. In fact there will be a month week in the month of June when health plans will get their applications back from the marketplace people.

And if there - it's there possible they may be told that they need to shore up part of their applications such as perhaps their contracting those ECPs.

So there will be an opportunity then. There will be opportunities throughout the year to keep getting added to the provider networks.

There is also a - the letter about this that went out to potential community providers at least those that are on HHS's list.

That letter went out on Monday with a set of FAQs. And the link to that letter and FAQs will be included in the digest that you - that will be sent out I think tomorrow.

Tracey Orloff: Today.

Colleen Meiman: Today okay. Also there was a document in the digest a few weeks back document prepared by NASHP National Association of State Health Policy that went through what the different requirements were for how many and what types of Essential Community Providers these marketplace or QHP plans must include.

So do you want to ask if there's any questions right now or...

Woman: Sure.

Tracey Orloff: (Julie) if you could ask if there are any questions that would be great.

Coordinator: Thank you. If you do have a question please press star 1 on your touch-tone phone. You will be prompted to record your name.

If your question has been asked you can press star 2 to remove yourself from the queue. Once again please press star 1 and one moment please. Ma'am I'm not showing any questions at this time.

Tracey Orloff: Okay great. Well I'd like to turn it over to Jim Macrae who has joined us so go for it.

Jim Macrae: Thanks Tracy. Hi everybody. Nice to see you all well not see you at least hopefully hear from you all at least talk to all.

Woman: At you all.

Jim Macrae: Happy Thursday. Is it Thursday?

Woman: Yes it's Thursday.

Jim Macrae: Everything's sort of a blur. I don't know how it is for you all out in the states and the regions but definitely things here in Washington it is fast and furious, lots of activity going on, lots of different things happening.

We actually are having a call at 3:30 today. I think most of you are aware around the outreach and enrollment opportunity for health centers.

We encourage you if you can to sit in on that call. We're going to shares some basic information about what is expected with respect to those applications and most importantly be able to answer any questions that folks may have.

So we'll encourage you all to participate in that meeting. We actually will end this call a little bit early so that we can do that transition but really value your feedback and input on that.

In terms of a couple of things that I wanted to share one was I did - I didn't want to go over in complete detail what I did on the all programs call last week but I did want to just spend a little bit of time on our spend plan, and a little bit of time on our program oversight shifts.

And then most importantly open it up for questions. And then we have a couple of other topics that we want to share both from a policy perspective as well as from quality and data.

In terms of our spend plan just to give you the ballpark of what we are doing over the next several months it is like landing planes in a lot of ways in terms of the different activities that we have going on.

The first plane that we're going to land is the continuation awards. What we are going to be doing first is to make sure that all health centers receive their full 2013 award.

We're going to make everybody whole with the June award announcements. So, you know, for folks who have been asking yes they will get their fall 2013

level. We have not applied the sequester to any continuation awards and people will get their full amount in June.

The second landing thing is the outreach and enrollment. We do have a relatively quick turnaround time in terms of both the applications as well as the awards.

But we hope to be able to make those awards in early June so that health centers...

Woman: July.

Jim Macrae: Early July sorry I get you in July mixed up July. Had to catch your breath there for a minute July as early in terms of getting those awards out because we really want health centers to be in a position to begin the hiring process so that folks are fully ramped up and available to start the outreach and enrollment not only October 1 but even before that because there are a lot of folks who are currently eligible for Medicaid that aren't enrolled even now.

The next set of awards that we'll be making are related to base adjustments. We have $48 million that's available to support health centers with base adjustments.

We anticipate making those awards in August. And those awards will support health centers with the increased cost of care that they're experiencing as well as to sustain many of the quality improvement activities that they've been engaged in in particular around the patient center medical home. We

want to make sure that folks have that additional resource to help support them.

And then finally the last piece is new access points which we hope to award in early September which is to support health center new access points.

Right now we have $19 million available to support 25 new access points. And we anticipate making those awards in September.

Let me just jump to the question that's already been asked a few times. What about the other applications that have come in and are in the approved but unfunded category?

Those applications will be good for up to a year from the award date. So they will be good up and through late August early September in 2014. So we will have those applications available.

In addition -- and I think (Suma) will talk about this in her update -- we are going to be making some I think it's a small number but some additional network awards.

We had a competition out there and we do anticipate making those awards sometime this summer. And I'll let (Suma) talk more about the specifics related to that.

So a lot of different activities going on with respect to the spend plans. A lot of different pieces that I think will be extremely beneficial to health centers especially existing health centers to help them both with outreach and

enrollment as well as dealing with the increased cost of care in some of their quality improvement activities.

But clearly a lot of opportunity as well as some more limited opportunities around new access points.

The one piece that I will say just related to outreach and enrollment because I know this is probably on a lot of people's minds is that this is going to be a big, big activity.

We are investing $150 million to do this. This is just to give you a sense of perspective three times the amount that's actually going out in the navigator program.

And so there are some significant expectations related to this in terms of for health centers, in terms of really doing significant amount of work around both outreach and enrollment.

And we do see this as doing what we call in reach. So helping health centers with their currently uninsured patients enroll whether it's in a marketplace, or in Medicaid, or in ship but also an expectation that they will be doing outreach in their communities in the service area to people that are uninsured and are looking to enroll.

And the intent is that we want people FTEs to actually help with this whole process. To help people literally walk through the enrollment process.

So all the different pieces that people need to be aware of, everything from signing up for an account, to helping them determine whether their eligible

for the marketplace or Medicaid, to what are their different insurance options that they have as well is ultimately enrolling in a plan or into Medicaid or CHIP itself. So it is labor intensive but it's really important in terms of the work.

The other thing is that in terms of the actual expectation I want folks -- and I would ask you to help me with this -- to be realistic too in terms of what they're proposing to be able to do because there's going to be a lot of attention and spotlight on this.

So as part of the application we're going to ask folks to be clear about how many people you're going to hire which is fairly straightforward but how many people you're going to train which includes both existing staff as well as the newly hired staff.

And then the important ones is how many are you going to assist? And then how many are ultimately going to enroll?

And we don't want people to go crazy either too low or too high in terms of what those numbers look like. We really want people to be realistic in terms of what they think they can accomplish.

And, you know, as a rule of thumb, you know, they can look at what it currently takes to enroll patients into, you know, Medicaid and CHIP at their current sites and sort of use that as a proxy.

It will be in some ways a little bit more complicated but at the same time a lot easier in that it's through a Web portal so it's going to be easier than it's been in the past.

But there's going to be more options. So it's going to be taking more time I think with patients to help them pick through what the different options are.

So, you know, there's not a hard and fast rule, you know, we've heard anywhere from it might take people an hour, to two hours, to three hours to help people enroll depending on the complexity of just the size of the family the different options.

But we really want people to be realistic about what they can do in their projections and what they ultimately can do because there will be a lot of attention on this just to be honest.

The other thing is that there is an expectation that all of these folks will be trained through either national required training or if there are additional state level trainings that are required.

So there is an expectation that all of these staff will ultimately pass some sort of certification test to be able to do this work.

And it's really important that the people that are doing this work are certified and trained. That's absolutely critical and essential to the work.

And people can use some of their resources to help with that training although most of it's going to be available on the Web so that it will not be costly except for just the amount of time that's required to do it.

And right now the estimates are anywhere from 20 to 30 hours of time that will be required to do the training.

The last piece which I know most of the cooperative agreements are interested in is well that's great Jim we're really happy for the health centers but what about the cooperative agreement?

We do and we have heard that loud and clear. We are looking to see if we can do something with respect to cooperative agreements.

Hopefully at a minimum something that would be one time to help with really the big push related to all of this but I'm still sorting through what our numbers are at this point. And so I can't say definitively yes or no but it's definitely on our radar screen.

You may say well it's already May what is it may 16th how can you not know? Well I think it's similar to the Defense Department is still trying to figure out whether people are furloughed or not and how many?

Our final numbers are still not completely resolved in terms of the sequestration and the impact. So we are still trying to work through all of that.

But I do hear folks. We are looking at it so please know that I will do everything that I can to see if we can get some resources out to cooperative agreements to support some of these activities but in particular around outreach and enrollment.

I think that's enough for that. Let me jump into a couple of the policy things and then just a couple of things in terms of program oversight. And then I will open it up for questions.

So in terms of program policies that we're working on we are working on our sliding fee discount PIN. So we have gotten a lot of good feedback, and a lot of comments, a lot of recent feedback and comments about how does the ACA impact our decision making around the sliding fee discount?

I think as a shared on all programs call last week the biggest struggle that we're having is just how do you strike that balance between the mission and financial viability.

And it's always that tension between making sure that the services we provide our assessable and affordable but at the same time not in a way that completely runs the organizations into the ground so they can't actually continue to provide the service. And so what's that right balance is what we're trying to strive for.

And there isn't a perfect answer. And I think that's probably what you'll see but we're trying to strike that right balance.

A second piece for us is related to the QI programs. We clearly know and the IG and others have told us that we need to put out a QI PIN to have more clarity around what really are the expectations.

And again I think some of those sliding fee discount we're trying to balance what's reasonable what sort of the baseline expectations versus what is more aspirational in terms of a quality improvement program.

So we're trying to really determine what those baseline elements are and build from that in terms of establishing a good plan.

And the intent is to actually have those standards be something that would apply also to our FTCA programs so that you have one set of expectations to deal with related to QI both for the health center program as well as for the FTCA program.

We also have done updates recently on our change in scope process. We've actually added a lot more questions.

But the intent behind adding a lot of those questions was that we wouldn't have all this back and forth that we've been having between project officers and grantees that frustrates everybody.

So what we did is we basically took a timeout and said hey what is it that we absolutely need to be able to make a decision?

Let's ask those questions so that grantees do it on the front end so that we can make a decision quicker on the backend. And that's what we're attempting to do.

You know, we'll look at this process over time to see if it's working to what we intend it to do. We know it's a lot of questions but these are significant decision that grantees are making.

And in some cases if they don't go through these questions they make bad decisions and get into places where they say they can do something and then it's turned into - it's basically run them into the ground.

And so we're doing some of that upfront requests to make sure that they've thought through how can you in particular sustain this new site or this new service is really important because we think too many health centers make bad decisions.

And it was a good opportunity but they didn't think it through and so just making sure that people think it through before we improve it. It doesn't benefit anyone for them to not be functioning and operating.

And then finally the last one is our whole total budget piece which really relates to stuff that you've heard me talk about so I will go into a lot of detail but we've been having the IG go out and do a number of different reviews of health centers.

And they've been finding a lot of unallowable costs. And it's been primarily because health centers can't document clearly what's paid for with federal versus nonfederal dollars.

And we've been spending a lot of time and the grantees have been spending an inordinate amount of time trying to justify their budgets.

The good news is the most of the time it's been successful but we're still having situations where there's significant disallowances.

And it's just - it's not helping anyone to do this. And so trying to be proactive and preventative we're going to be asking for folks to submit federal and nonfederal budgets to make sure that it's clear about what is covered and what's not covered.

But also at the same time let the nonfederal piece be allowed to do what it is that you need to do to still operate so just to make that clear especially to the auditors and others so that you can do what you need to do with the nonfederal.

And we're clear about what the federal can and can't do. So we're hopeful that this will actually help alleviate a lot of issues that have been coming up.

The IG is going actually be going out a lot more to different health centers across the country as part of the Affordable Care Act program integrity reviews. So doing this on the front end we think is going to be really beneficial in the long term.

We will be putting out a PAL soon that says all of this as well as updating our 2014 both what we call the service area competition as well as the budget progress report with that federal nonfederal budget.

The last piece really relates to program oversight. Again you've heard me talk about this before so I won't go into great detail.

But the GAO review really did ask a number of things of us which has had a significant impact both on us and in turn on the grantees.

In particular really the expectation around documentation both of whether somebody is in compliance they're out of compliance.

As I've shared with many of you it's almost like clinical work now that you may have done it but if it's not in the patient record you didn't do it.

That's very much similar to practice that we're seeing now with health centers in terms of whether it's compliance or activities that they're doing with respect to their budgets.

So if you don't document it you didn't do it even if you did do it you didn't do it. So that's caused us to do a lot of things that have required a lot more documentation both from grantees as well as from our own staff that has created a significant amount of reporting burden.

At the same time the GAO is definitely asked us to make sure that when we do find different conditions and issues that we resolve them in a timely manner, that we really work through all the steps of our progressive action, and that we have a system for tracking that over time and making sure that, you know, issues are addressed appropriately and if they're not that actions are taken. So we've been getting a lot in terms of making sure that grantees are doing what they need to do.

We also have been pushed to do operational site visits more often. Early suggestions whether we do it every year in terms of those operational site visits we were able to work through and we've gotten to a point where now we're doing them every three years in terms of those operational site visits but that's part of this larger package that we're doing.

And then finally the last piece which is something that we're working on is going to take us a little more time is providing better guidance on the requirements.

So we've done a great job in terms of getting clarity on what the requirements are. But there's a lot of nuance and a lot of, you know, what

does that actually mean that we need to do more of both for ourselves or our consultants who are going out and doing reviews, and then of course for you as cooperative agreement partners, as well as grantees and networks and others so that people understand it.

With all of that, you know, I think the biggest part for us is that we were -- and I think we did a great job in responding -- but we weren't as strategic as we needed to be with respect to the GAO.

We just, you know, with anything that sort of happens and is thrown at you you respond. But what you don't always do is look at okay but can we actually sustain that over time?

You know, we basically we added to our work to meet all the different requirements. We then added to the grantees in terms of you all meeting all the requirements but is that really sustainable over time?

And talking too many of you and in getting feedback grantees satisfaction surveys and other things we just said hey timeout we can't do this. It's just not - it's not going to work.

It doesn't make sense from where we sit. It doesn't make sense from where the grantees sit. And there are many other things that need to be addressed.

You know, we have this thing called the Affordable Care Act to implement so we've got to think through how do we do all of this.

So what we are proposing to do is to actually shift to three year project periods from all health centers basically asking at the beginning of a project

period that people submit that full blown service area competition application that addresses all the compliance issues, you know, shows how people are meeting them, as well as what their performance and outcome goals are both clinically and financially in terms of what they want to accomplish over the next three years.

Then in the second year at the second year milepost we used to ask for a full blown budget progress report which basically asked for very similar information to what was in the SAC.

It was basically another compliance review that we were doing on top of what we had done before as well as providing information on how the organization was doing both clinically and financially.

What we decided though was that's just - that's too much because now we're doing operational site visits every three years. So do we really need to do that?

So we said no we really don't. So what we're going to do is in that second year ask for a budget progress report that is much more focused on progress and really much more of a progress report in terms of how are you doing as an organization.

And it's going to move away from asking all of those compliance questions. So were basically going to eliminate that.

And I don't have it exactly front of me but it's going to reduce the size of the application by we expect more than 75%. So it's going to be significantly stripped down in terms of what we ask for.

And basically in terms of this application it's going to ask, you know, has there been any changes in the environment that have impacted on your organization?

You know, the Affordable Care Act how is it impacting your organization? Have there been any changes in the capacity of your organization to actually meet what it is that they need to do?

How are you doing in terms of your clinical and financial progress? So in terms of those performance measures how are you doing? What progress are you making?

And finally if you've gotten new funding how are you doing in terms of implementing a new access point? How are you doing in terms of your PCMH activities?

Part of that is to also get us away from some of the separate reporting that we've been asking for some of these additional supplements.

So to really trying get at that. And then finally that budget. So updates to your budget for that next coming year. And that's basically it terms of what we're asking for.

Then at the midway point of your project period so sort of at the 18 month mark and it may be a little bit one way or the other to do that operational site visit.

So basically go on site and do that verification of compliance as well as how is that organization doing from a performance standpoint.

So really to sort of supplement what we've done with the SAC in the beginning where it's more of a desk review now we'll do an onsite review to see how the organization is doing in terms of their meeting the standards and the expectations.

And we know we need to streamline and update that site visit guide and we're working to do that to make it more focused on what really needs to be looked at.

And then making sure that consultants know exactly what they're supposed to look at because we do hear, you know, you all share with us that there is some inconsistency. And we know we need to correct that.

Then at the second year mark sort of, you know, 24 months in we'll do a second BPR if it will again be that streamlined version.

So again have there been any changes in the environment any changes in the organization? How are you doing on your clinical financial performance measures? How are you doing in terms of implementing some of your supplements and a budget so again very much stripped down?

Not that full blown application that we've asked you for. And then at the end of the three years people would come in for their SAC which would basically start the whole process over again.

Yes there's a little bit of a tradeoff in terms of, you know, moving from what we had done with a lot of grantees, you know, it's about 60% were five year to move them to three year.

But we really feel like the tradeoff is more than worth it in terms of reducing the burden on grantees. We think it will make a significant difference in terms of what's expected.

And, you know, if we kept it a five year it would have - we would have been in a position, you know, given some of the GAO there we were doing, you know, five full blown application reviews, two onsite reviews during that time period, it just - it didn't make sense.

So this proposal meets intent of the GAO. It meets our expectations in terms of compliance with - I would say just a small trade off in terms of the length of the project period but I think really puts us all in a better position to be successful.

So that's what we're trying to do. And I would say that's something we're just trying to do with everything.

And I know you all are trying to do it from where you sit is really, you know, with everything on our plates how do we do what we're doing better, and more efficiently and effectively because what has gotten us to where we are may not necessarily be what's going to take us where we need to be.

And really thinking much more strategically about how do we do what it is that we're expected to do with the resources that we've got.

I just think that's so critically important terms of the work both for us for you as corporate agreement partners, networks, others, health centers in terms of just what we're doing going forward.

So that was a lot. Let me stop there and see if there are any questions that folks may have on any of those different pieces.

Coordinator: Thank you sir. Once again if you do have a question please press star 1 on your touch-tone phone. You'll be prompted to record your name.

If your question has already been asked you can press star 2 a new touch-tone phone. Once again please press star 1 at one moment Sir.

(Jody Samuels) your line is open.

(Jody Samuels): Hi. Thank you. Yes I just have actually three quick questions that are sort of all related to funding issues. And these are mostly questions we've actually been getting from our members.

So the first one is for the new access points I know in the all grantee call last week it was mentioned that those would be launched in September.

Is that meaning the FOA will be released in September or the awards will be made in September?

Jim Macrae: The awards will be made in September.

(Jody Samuels): Okay. And then so are they based on applications that were already received in previous rounds of those applications?

Jim Macrae: It's the current competition that's available. We had I think it's a little less than 400 applications that have come in...

(Jody Samuels): Okay.

Jim Macrae: ...that we're reviewing. So it's for the 2013 cycle.

(Jody Samuels): Those ones are still under review?

Jim Macrae: Yes.

(Jody Samuels): Okay great.

Jim Macrae: The - these are meeting like in the next two weeks I think yes shortly so...

(Jody Samuels): Okay wonderful. And then is there going to be a new round of teaching health center funding that you're aware of?

Jim Macrae: That's a good question. We'll have to check with our colleagues in the Bureau of Health Professions. I do think they are interested in doing it.

I think the only concern is, you know, they've heard from some applicants are they willing to do it given the limited timeframe and just what's the future of the program but we can check with the folks in our sister bureau about that.

(Jody Samuels): Okay. That would be great. Like I said we've been getting questions from our members about that.

Jim Macrae: Sure.

(Jody Samuels): And then the last one that we've been getting quite a few questions about is everyone's very pleased with is going to be the $48 million base adjustment that will be rolled out in August.

But everyone wants to know exactly what that formula is. And I did know if you could share more information about that?

Jim Macrae: We're still working on it so I don't have an answer yet. But, you know, I think it'll be something similar but the amount of money is less to what we have done with respect to the outreach and enrollment.

But we still need to figure that out. You know, will we do it based on number of patients, you know, the outreach enrollment is based on the number of uninsured patients will we do it on number of patients, will there be some base amount, those are all the things that we're trying to work through. We haven't figured that out yet though.

(Jody Samuels): Okay great. Thank you. Just if, you know, as soon as...

Jim Macrae: Yes...

(Jody Samuels): ...you have that and it's possible to share it I know everyone really wants to know.

Jim Macrae: I know. I understand.

(Jody Samuels): Okay great. Thank you so much.

Jim Macrae: I do too.

(Jody Samuels): Yes right I'm sure. Thank you.

Coordinator: Thank you. The next question comes from Ms. (Siebell). Your line is open.

(Siebell): Oh it was an earlier question of how you get an application for the QHP network?

Jim Macrae: So in terms of an application for the Qualified Health Plan how do you...

(Siebell): Yes.

Jim Macrae: ...get a copy of what the application was that was submitted?

(Siebell): No to get on as part of an ECP Essential Community Provider to be part of that network?

Jim Macrae: Yes great question. It's actually - it's one of the -- and I will do this as a plug -- but the primary care digest just came out I think within the last several minutes. Is that correct?

Woman: Well for the cooperative agreement that will come out...

Jim Macrae: Okay.

Woman: ...in an hour or two for the grantees...

Jim Macrae: Okay so...

Woman: ...yes we're going...

Jim Macrae: ...in our primary care digest which I hope you're on the mailing list, and please do not delete it, please open it, it's really valuable in that there's a lot of good information on that.

The first thing in the digest is actually set of frequently asked questions that actually addresses your particular question about if I'm an ECP what are the steps that I need to take to be able to find out who the Qualified Health Plans are, what steps can I take to get more information about this whole process?

So there's a whole set of questions from CMS because we've got a lot of those questions and CMS to their credit has developed these sets of answers. I just I don't have it right in front of me but I would direct you to that to answer your question.

(Siebell): Okay thank you.

Jim Macrae: Sure.

Coordinator: Thank you. (Vanessa Santarelli) your line is open.

(Vanessa Santanelli): Hello. Thank you for holding this call. This might seem like a simple question but up in Maine we've received a number of requests from our health center members on offering assistance on the outreach and enrollment applications.

And as you know, you know, we're sort of dealing with limited resources in this sort of fiscal environment and appreciate that you're considering offering potential one time support to the PCAs.

But from your perspective do you have any specific suggestions on what could potentially be the most effective ways that we could help sort of the, you know, all of our members collectively whether it's, you know, specific parts of data that - or any other suggestions that you might have that we can share collectively with our members?

We're getting sort of individual request but want to make sure we're maximizing our sort of our efforts to be consistent with our cooperative agreement responsibilities.

Jim Macrae: Sure. It's a great question. I think in terms of application itself once grantees receive it and if they haven't had the opportunity they may want to go on our Web site because we have models of it.

It's very straightforward in terms of the application itself. It is a very I would say streamlined application process. So people shouldn't I would say stress out about the application.

I mean what they need to do is make sure that they're realistic in terms of what their goals are, and expectations, and all of those different pieces and not do anything that's not allowable. And we hopefully have laid that out very clearly about what's allowable or not.

But I think where it's really going to be needed and we're working with our colleagues in CMS and others and we're going to be doing a series of conference calls and other things with you all as well as with all the grantees is okay what are the best strategies to actually do this?

So we're going to be identifying, you know, health centers primary care associations that have done this kind of work to help us with getting the word out in terms of what really works.

I think, you know, just based on what I've seen, you know, one of the best things is what's your strategy for reaching those people currently in your health centers that are uninsured.

So how are you going to do, you know, how are you going to get folks in the door or as patients have appointments what's your process for making sure that they are signed up and enrolled?

Then how do you do outreach to people that you've seen but maybe aren't scheduled for an appointment how do you get them, you know, either in the door or working with them to make sure that they enroll?

And then where are the pockets of uninsured patients that are living in your community? And we've been working with our colleagues in the department and I think you may have heard but they are literally identifying people down to like -- I don't think it's down to the block -- but down to certain level so you can actually see where the pockets of uninsured are in different parts of the country.

And so we're going to be providing some of that data and information to you as well as to the health centers in terms of the work itself.

But, you know, I would just tell you to reassure folks now in terms of application, you know, definitely listen to the call or if they can't listen to the call listen to a replay of it.

Don't freak out about the application. Where they need to start freaking out is the actual doing of it which we're going to provide a lot of support to help with that part.

(Vanessa Santanelli): Okay thank you.

Jim Macrae: Sure.

Coordinator: Thank you. The next question comes from (Clifford Chang). Your line is open.

(Clifford Chang): Thank you. Hey Jim hey Tracy I'm happy to take this up off lime but this is related to the outreach and enrollment.

The way that the grant is structured -- which I think is really fantastic -- but it has very little applicability to the Pacific islands in that number one they don't really operate under health insurance as you know they're all government funded healthcare.

And so it makes little sense for them to spend three like American Samoa gets $300,000 for - and they - it to do outreach with little like little to accomplish by doing so. They're not going to bring more people in to enroll in insurance.

The places they get treatment is either at the health center or the hospital. So they might be able to bring more people in through outreach but it's not going to be to the tune of $300,000.

I'm just wondering what kind of flexibility is there or should I bring this up with the project officers and how we can make this be effective in getting more people access to services but it won't be through the way the program is structured.

Jim Macrae: Well I mean in terms of that I think what's important is that the resources are very targeted to outreach and enrollment.

So there is limited flexibility (Clifford) in terms of, you know, what people can and can't do with respect to the money.

But, you know, folks are eligible to apply up to that amount. If it doesn't make sense in terms of that amount for the work that they're going to do they shouldn't apply.

In fact we've been encouraging health centers they, you know, if this does not make sense from where they sit don't apply for the full amount.

That's absolutely a reasonable thing to do. But we do, you know, and then that part of the formula is because there are a lot of uninsured so clearly there is something's going on in terms of the numbers that's happening in terms of outreach and enrollment.

You know, we can talk more off line but I think the bottom line is that there's limited flexibility in terms of what the purpose of these dollars is for.

And if folks can't, you know, meet the intent that's okay they just - they shouldn't apply for that full amount.

(Clifford Chang): Okay. I'll be happy to take it - I mean I would like to follow up with you off line. And I can do that through the project officer's interview.

Jim Macrae: Sounds good.

(Clifford Chang): Thanks - thanks Jim.

Coordinator: Thank you. The next question comes from (Susan Wilson). Your line is open.

(Susan Wilson): Good afternoon. I think some of my question may have already been answered in the discussion about the outreach and enrollment.

But I noticed that the patient navigator term was not present in that discussion. So I'm curious about how you see the patient navigator grants that are going to presumably statewide organizations interacting or intersecting with the outreach and enrollment support?

Jim Macrae: Yes. The navigator program a couple of different things related to that. One there's been a question about whether health centers are still eligible to apply for navigator?

The answer is yes. Health centers can or primary care associations can. So there's not a prohibition about that in terms of what people can and can't do.

I think the realities though are that, you know, once people, you know, look at the different applications they may decide that the outreach enrollment makes more sense.

Clearly one of expectations that we have is that there is some level of coordination between what's going on with the navigator program and what we're doing with respect to outreach and enrollment.

In fact that's one of the things that we asked for from the grantees. It's one of the things that we one of the few things that we do ask for in terms of that collaboration piece.

In terms of the real differences there are some differences but the differences are not significant between what we're asking navigators to do and what we're asking our folks to do through our outreach and enrollment.

It's very similar activities. In fact even the training itself our trading that we're going to have folks go through is going to be very similar to navigator.

The navigator will have a little bit more just given some of what they're asked to do in terms of their Web portal but it'll be very similar.

The only other thing that I would say is they - we've made it very clear in the guidance that we can't supplant.

So if people do get navigator money they can't use it to supplant the resources that we're providing here or vice versa.

So we're actually as -- and I think I mentioned it - we're going to have some of our colleagues from CMS come and talk on some of these calls about what the navigator is doing, how we can coordinate and how we can leverage.

But I think the bottom line is we're trying to get more people out there in terms of doing this outreach and enrollment activity.

And we're going to do the best that we can to coordinate at the federal level, and you all at the state, and then ultimately at the local level in terms of this work.

(Susan Wilson): Okay. Thank you.

Jim Macrae: Sure.

Coordinator: Thank you. And as a reminder you can press star 1 if you have a question and star 2 withdraw your question. The next question comes from (Rebecca Whitaker). Your line is open.

(Rebecca Whitaker): Hi. Thanks for the call and for all the work you all do. I just have a quick clarifying question around the sliding fee scale PIN. And you mentioned how the ACA sort of complicates some of the policy there.

So I'm just wondering whether the PIN will address some of the issues related to private insurance like the 90 day grace period for nonpayment of

premiums and whether the sliding fee would apply during that period of time?

Woman: Hi. That's - those are all a lot of the really big questions that are being looked at right now in developing the final PIN.

There's a lot of complexities in how health centers approach their sliding fee discounts in - as they relate to all of the different options or all the different things that are available to patients in supporting their care.

And so those are definitely things that have been brought up both you the comments and through the current period as well as through some of the complexities that have come out through the ACA and those are a lot of things that we're tackling right now.

So I can't give you a specific answer to that individual question but those are all the things that are hopefully going to be addressed in the final PIN.

(Rebecca Whitaker): All right. Thanks.

Coordinator: Thank you. The next question comes from (Joy Tresagie). Your line is open.

(Joy Tresagie): Hello. Thank you. As many people have said already thank you for taking the time to have this call today.

And I was excited to hear about the QI PIN. And my question has to do with, you know, will these - will any of the benchmarks or measures include children?

And if so where are you looking to sort of get your basis of information to create the system that you're looking to create?

Woman: Great question. I think as Jim mentioned, you know, the balance that we're seeking to strike in the QI PIN.

It's going to give you higher level guidance on what are some of the minimal baseline expectations of an overall quality management quality improvement system at your health Center including things like peer review, using data to drive quality improvement, going through, you know, continuous quality improvement process but it probably won't get into the details of the how you should do that.

I really think that's health center specific based on the population you have the type, the type of providers, and what are some of the prevalent conditions that provides the flexibility for you guys to choose which ones.

Of course a great starter place for any of those metrics would be the UDS set of metrics it crosses the entire life course and there's a variety of different measures you can use from there.

But clearly it's up to the health center to pick those performance measures and data sets that are most relevant and - to your needs.

(Joy Tresagie): Great. Thank you.

Coordinator: Thank you. Once again if you do have a question please press star 1. And sir I'm showing no questions at this time.

Jim Macrae: Great. Well at this point we'll actually shift to (Suma). That was a good transition actually in terms of getting an office of quality and data update. So...

Coordinator: Sir I'm sorry we do have one more.

Jim Macrae: Okay.

Coordinator: One moment. (Louise Reese) your line is open.

(Louise Reese): Sorry to be that last question for this section. You mentioned that health centers can apply for the navigator grants.

And I assume then that they may also apply for the state funded IPA grants that will also come through HRSA.

And our state Office of Insurance Commission has asked several questions about how we will coordinate those activities and between health centers that receive state HRSA funds through them as well as the outreach and enrollment through the bureau?

Jim Macrae: Just I'm - I just want to make sure I'm understanding. The state IPA through HRSA what is that? I'm not sure I...

(Louise Reese): Okay. West Virginia has the State Partnership Model. And the Office of the Insurance Commissioner will be applying for a HRSA grant -- I believe it's HRSA or maybe it's CMS?

Jim Macrae: I think it's a CMS grant.

(Louise Reese): It CMS okay. For IPAs...

Jim Macrae: Yes.

(Louise Reese): ...In Person Assisters.

Jim Macrae: Yes.

(Louise Reese): Health centers are eligible to apply for those funds.

Jim Macrae: Yes.

(Louise Reese): So our concern is how do we coordinate between the expectations of that program as well as this program?

Jim Macrae: Well I think the good news is that we are trying to align with both what's going on at the federal level as well as within state.

So within our applications ourselves what we're saying is that in terms of the training, you know, there are state based marketplaces, there are federal marketplaces and then there's these partnership models.

In the state based marketplaces the states received resources to actually support navigator and in person enrollment.

And there about I think it's 19 different states that are doing that. So they receive money to actually support outreach and enrollment and assister activities.

You know, it depends on every state in terms of how they're doing it in terms of whether they're, you know, how they're making the money available.

Are they making it available to health centers? Are they doing it through health departments? Are they doing it to other community based organizations how are they doing it?

What we've said and we've talked actually to the state commissioners -- in fact I'm going to be on the call at 4 o'clock sort of in the middle of our outreach and enrollment call to actually talk to them about this -- is that what we're doing is providing resources to help them expand their capacity.

The states can absolutely add more to help increase that. The key though is it's just going to be that a health center is showing how there different resources are adding to and not supplanting each other.

(Louise Reese): Right.

Jim Macrae: But in terms of expectations, in terms of training, in terms of what the functions and responsibilities are, I think they're going to be very similar in terms of what we're doing. It's just really expanding the capacity of health centers to do even more in these areas.

(Louise Reese): Thank you.

Jim Macrae: Sure.

Coordinator: Thank you sir. And I do have no other questions at this time.

Jim Macrae: All right then I'll turn it over to (Suma).

(Suma): Excellent. And so I'll quickly provide a couple of highlights just to draw your attention to but in the interest of time so we can all jump on the outreach and enrollment call I'll keep it somewhat brief.

One I'll just start with the UDS reporting. Thank you all for your support again by cohosting some of the training sessions as well as your support in getting the health centers to submit their data.

We - we're done. We got all of the date on time. And we anticipate to be able to share the 2012 UDS data later this summer.

One of the things about sharing that data as you know we continue to push the envelope in the way we present our data on the Web site.

And last year we were able to get all of the individual grantee level data out on our Web site. And they were in somewhat less sophisticated format PDF files but everyone had access to the data.

We are going to raise the bar some this year by providing new data views that we think will be really useful for all of you, for the health centers, as well as the public to get a really good sense of the great impact health centers are having.

Some of the data on the patients, the demographics, clinical outcomes, your successes in terms of the EHR, PCMH, et cetera.

So look for some of that later this summer. And we will have a once the Web sites are live and up and running probably a TA call just to walk you through that so everyone is aware of what great information is available publicly on the health centers.

Similarly related to UDS we encourage you all to look at the upcoming Bureau of Primary Health Care Weekly Digest.

In there you will find a link to the upcoming calendar year 2014 UDS PAL. So we've posted some of the measures that we're looking at and changes that we anticipate making to 2014 UDS.

And of course as with every year that comes with an opportunity to get your feedback and comments. There will - it will go through the official federal register notice process.

And the comment period will start at that point. But as a kind of prerequisite to that work we're putting this out there so that you have an opportunity to look at it.

Just a quick couple of things to give you a sense of what's coming down the pike with respect to that --and then you can read more in detail when the PAL is posted -- we're going to add some additional information around our public housing patients and so we're excited to include a line in the Table 4 for that information.

We also have added some information again to support our activities with the national HIV-AIDS strategy and the further integration of HIV care into primary care services.

We are adding an item on Table 6A that identifies patients who were diagnosed with the first time with HIV. And so this HIV positivity rate will be in the UDS Table 6A.

We're also adding on the clinical Table 6B some data around linkage for those who are identified as positive into care so both of those data collection efforts and measures really will go to advancing the national HIV-AIDS strategy.

And again, you know, one of the very many efforts that we've done in line with the recent PALs, and training and technical assistance opportunities, and funding opportunities to advance care for that population.

With respect to some of the other clinical measures you'll be very happy to know that we are streamlining some of the measures that in our alignment with meaningful use requirements, other accrediting like a NQF and other bodies they've made changes to their measures so we've adopted those as well.

One example is the smoking measure. There was two different measures on tobacco cessation and intervention. Those are now being combined.

The lipid therapy measure is being replaced with an outcome measure around lipid control so that's very exciting. We've had many conversations about moving to more outcome measures whenever possible.

And this year we're particularly excited to highlight the proposal to add a measure around clinical depression screening and follow up.

As you know behavioral health and oral health are priorities for the health center program. We have been collecting measures on those but they were opportunities in lieu of great standardized measures to use we allowed each health center to pick a measure that worked for them.

We have a really good clinical measure that we're proposing now for that the ones that align with meaningful use and other incentive payments.

We're going to propose that. So I think it'll be helpful for the entire health center program to have one standardized measure around behavioral health. And again that just supports our effort to integrate those services in our patient centered medical home.

So those are a couple of the high level elements that we have. Please look at the PAL for more information. And we really look forward to receiving your comments on these proposed changes.

FTCA again thank you all. All of the submissions were submitted on time. It was hairy there the last day but we got all of the deeming applications in.

We're working on the deeming determinations. For those who submitted a complete application with all the information that was necessary and responsive application those should be moving right along in the process.

And there were some that we had requested additional information. And so that will push the timeline out for those a little bit.

Again thank you all to the NCAs and PCAs for your support. We've seen ramped up effort in light of some of the challenges we've identified with the quality issues, risk management, patient safety, training opportunities you all have stepped up and really done a lot of that.

Leveraged that ECRI resources we have, the FTCI team we have, and I think a lot of that has gone - done a lot to support the improvement in patient safety, risk management, and quality improvement activities we see across the health center programs. So thank you for that and please continue those efforts.

Patient Centered Medical Home I'm happy to report as of May our latest data that we are at 22% of health centers being recognized as Patient Centered Medical Homes. Well on our way to our goal of 25% by the end of this year followed by the end of September.

Related to our fiscal year 12 supplemental around Patient Centered Medical Homes we are hoping to get some feedback on grantees progress towards getting recognition as well as improving cervical cancer screening.

As a reminder those interim reports are due June 3. And really will provide valuable information on the progress to date, what some of the challenges are, and, you know, help us in guiding our training technical assistance efforts as well as some of our efforts around the various contracts that we have to support the recognition process. So whatever you can do to help health centers go through that that would be wonderful.

One of the leading barriers that we've heard from health centers around PCMH transformation has been the technology issue.

EHR adoption is phenomenal. Over 90% with the latest UDS have adopted Electronic Health Records at some level yet I think moving beyond adoption to truly using that data and getting out of the system has been a challenge.

We've worked with our partner cooperative agreements to host a series of Webinars identifying - targeting some of the leading EHR vendors across the health center program to identify how you can develop those reports out of those systems to support the PCMH recognition requirements.

So again those were listed in the Primary Care Digest. So please go back and look for those. The timing and information around those we hope that those will prove to be very valuable to address this key concern that was raised.

There's a fair amount of confusion amongst the timelines and deadlines for our funding opportunities around PCMH and the supplemental requirements as well as CMS's demonstration project.

Please just incur - a plug to reach out to us at oqdcomments@hrsa.gov or reach out to me directly where you have any questions so we can help clarify.

We want to make sure that there's no lack of progress as a result of any miscommunication or, you know, lack of clarity around deadlines. So please let us help at any way we can with that.

Health information technology I mention we have great adoption rates. What we're really focusing on across the program is those who have not adopted EHR in any sense.

And as we look at that cross tab it with people's clinical performance and patient centered medical home recognition you start to identify some trends.

And so we're really interested in supporting health centers that haven't made that transition understanding what some of the barriers are and supporting them because we think it's critically important for not only the quality gains that we're looking for but as we move in this reformed environment having those systems and data is going to be critical.

And then finally as Jim mentioned with the Health Center Controlled Networks we're happy to bring a new small group into the bigger group that we already have here later this summer.

And we anticipate having a quarterly call for any of those networks who are on there in June just to kind of go over some more information around the Health Center Controlled Network programs. So we look forward to having a few more health center controlled networks join the family.

And then the last note given all the communication that we've done at the bureau through our email communications, our quarterly calls, our all program calls another form that we saw an opportunity for was direct conversations with clinical leadership at health centers.

So we're happy to work on CMO forms. We've kind of put the idea out there amongst various groups and received a lot of great feedback on this concept and the opportunity one to create national dialogue around some of our quality strategy, and key initiatives, and some of the why behind what we're doing some of the - these things.

And then also create the opportunity more regionally and at a state level to have more intimate conversations with clinical leadership around what are some of the challenges and barriers they're facing implementing these national initiatives and really to support some of those, you know, provide clarification and support those discussions so more to come on that.

We hope to have our first call here in the next quarter. And I'll look forward to working with the clinical leadership in that way.

I think that's it for me in terms of updates. And so we can open it up if there's any questions otherwise we're...

Jim Macrae: Great all right. Thank you (Suma). Any questions for (Suma) or anything on the quality and data front that people have any questions about?

Coordinator: Thank you. If you do have a question please press star 1 on your touch-tone phone. You will be prompted to record your name. And one moment sir.

Jim Macrae: All right. Well I think because we've got about five minutes left because we want to make sure we do a good transition to the next call Tracy do you want to give an update on where we are with the veterans hiring initiative?

Tracey Orloff: Hello everybody. Good afternoon again. And one thing that's important about the hiring vets initiative is we clearly still around the country have a need for getting in really good providers in lots of different positions throughout the health centers around the country.

And it's not just clinical, it's administrative, it runs the gamut across everything we need to do. And now as we know we're really going to be focusing a lot on outreach in a moment as well.

And so just wanted to, you know, bring this to your attention again. You know, October 2011 the White House announced the Hiring Heroes Program in an effort to increase employment opportunities for veterans in health centers.

And, you know, as you're aware and you've heard from us before there's a lot of synergy and core values that are in common between former military who are now veterans as well as the health center program and that real passionate commitment to serving the public and so there's a real great opportunity there.

And in addition as you know the goal for the Hiring Heroes Program is really to be able to hire, you know, whether it be as many as we can for any sites across the country and where that need is.

And one thing that we've done that we'll be getting out to you in the next - within the next month is we've made some great partnerships with the Department of Labor who is really excited about working hand in glove with not only us at the federal level but has folks at the state level that can work with both you the PCAs well as people on the ground who can help with health centers and actually matching up vet's for the different positions that health centers might have.

And so what we'll be sharing with you is a little bit more about the Department of Labor's American Job Centers. And these organizations are located at the community level throughout the country.

And they focus on providing training, employment services, job search assistance, and they really have staff on the ground who help job seekers and employers match.

And we'll be sharing some information about how you can upload your job announcements for free on their sites.

And so that way you'll not only have your normal sites that you do but you as PCA's can help your health centers in your state with those relationships and targeting broader to give folks interested to come to your communities that the health centers where they need it.

So we - what we'll be sending to you is some real action steps and direct contact to help you connect to those folks who really are on the ground trying to find those matches for those veterans. And so it looked for that and we'll be providing those resources to you.

Let's see so - but in the interim until you receive more from us of course there is the HRSA Web site page that's on hiring vets.

And it has a lot of resources and contacts. And some of those contacts there where you can upload those encourage health centers to upload those job announcements and job vacancies for free.

And if for right now you're intrigued by what I've been telling you a way that you can find those job centers in your community is to go to www.servicelocator.org/onestopcenters.asp.

And that is just like we have Find a Health Center where you can put in a ZIP Code they have the same thing for finding these job center folks. So they very much be a great partner and match for us. So with that I will turn it back over to Jim.

Jim Macrae: Great. Thank you Tracy. Thank you all for participating. If there's any last question's we'll take those at this point otherwise we'll end the call and we'll take a little break. And then we'll jump into our outreach and enrollment call.

So operator if there's any last question's we'll take those otherwise we'll talk too many of you all in the next 15 minutes or so.

Coordinator: Thank you. And please press star 1 if you do have a question. Sir I'm not showing any questions at this time.

Jim Macrae: All right. Well thanks everybody. So take 15 minutes. Take a break. And then we'll be right back at it. Thank you.

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